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on Accreditation of Healthcare Organizations
Setting the Standard for Quality in Health Care

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Testimony by

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I am Margaret VanAmringe, Vice President for Public Policy and Government Relations of the Joint Commission on Accreditation of Healthcare Organizations. I appreciate the opportunity to testify on finding innovative solutions for our nation's medical liability system. Founded in 1951, the Joint Commission is the nation's oldest and largest standard setting and accrediting body in health care. The Joint Commission accredits approximately 15,000 health care facilities along the entire spectrum of health care services. Our mission is to continuously improve the safety and quality of care provided to the public. We are here today as an independent voice that is derived from both the multitude of expert opinion that we bring together on tough issues facing the health care system, and from our more than 50 years gathering daily information on quality and safety from the front lines of medical care delivery.

On behalf of the Joint Commission, I would like to take this opportunity to thank the Committee members for their hard work in passing *The Patient Safety and Quality Improvement Act of 2005*. When implemented, this landmark patient safety legislation will provide the cornerstone for effective reporting systems that assure confidentiality and encourage the sharing of lessons learned from the analysis of adverse events. Without surfacing richer information about the types and causes of medical errors, we will continue to experience preventable errors at unacceptable rates. Patient safety depends upon transparency of information as the basis for improvement and behavior change. This dependency creates a fundamental dissonance with the current medical liability system that drives too much of that information underground. As a result, neither patients nor providers benefit.

Background

Many proposals for solving medical liability fail patients because they do not effectively deter the underlying causes of the harm, such as medical errors. While in isolation these liability reform efforts may be helpful to some degree, there is an inextricable nexus between addressing patient safety issues and addressing medical liability reform that must be recognized. Consequently, it is essential to structure solutions to medical liability issues that do not address just the back end, but that also take into account the factors that lead to litigation and defensive medicine on the front end. By maintaining a dual focus on both safety and liability concerns, there is an opportunity to strengthen patient-provider relationships, restore trust between the affected parties, and change the way care is delivered.

This interrelationship between patient safety and medical liability concerns led the Joint Commission to convene a roundtable of 29 experts representing a wide array of interests relevant to medical liability and tort reform. The discussions and intense deliberations from the roundtable resulted in the 2005 publication of a White Paper, "Health Care at the Crossroads: Strategies for Improving the Medical Liability System and Preventing Patient Injury." This paper, which contained over a dozen recommendations, was a call to action for those who influence, develop, or carry out policies that can lead to ways to address the medical liability system, while developing an environment that focuses on patient safety. My testimony today will highlight some of the recommendations from the White Paper that, if addressed, would move toward a medical liability system and a health care delivery system that both meet the needs of providers and patients.

Need for Comprehensive Reform

Much has been written about the effects that rising medical malpractice premiums have had on the ability of health care providers to stay in practice and provide access to certain high risk services. It is estimated that each year $28 billion is spent on medical liability

litigation and defensive medicine combined.[1] On average, a medical liability case takes three to five years to come to closure.[2] Statistics suggest a strong likelihood that every surgeon will be named in a suit during his/her career. These are staggeringly true estimations of the magnitude of the problem, but they are also illustrative of the dysfunction in the medical and legal "systems." In fact, the current medical liability "system" is really not a system, but rather, a patchwork of disjointed and inconsistent decisions that has limited ability to inform the development of improved health care practices.

A number of studies have revealed the inconsistency of the medical liability system in determining negligence and compensating patients. We know that there are large numbers of preventable medical errors but only about two to three percent of negligent injuries result in a claim, and even fewer receive compensation for their injuries.[3] Conversely, only about 17 percent of claims actually involve negligent injury. This means that few injured patients receive compensation through the medical liability system, and that those who do get compensated are often not the victims of negligence. Further, compensated individuals receive highly variable recompense for similar injuries. What we have today is a system out-of-balance and lacking equity for its participants. In other words, we have a system that is not fair, not efficient, and not predictable.

Solving the rising cost of malpractice premiums will make things better but it will not result in an effective tort system or improved patient safety. Because what goes on in the court room and what goes on in our hospitals and other venues of care have become inextricably tied together, only a comprehensive approach to tort reform can alter the unfairness it imposes on patients and health care providers, and can lessen the deleterious impact it has on patient safety.

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[1] Iglehart, John, "The malpractice morass: Symbol of societal conflict," Health Affairs, July/August 2004.
[2] General Accounting Office, "Medical Malpractice Insurance: Multiple Factors Have Contributed to Increased Premium Rates," GAO- 03-702, July 2003
[3] Studdert, David M., Mello, Michelle M., Brennan, Troyen A., "Medical malpractice," NEJM 350;3, January 15, 2004

Recommendations for Consideration

The Joint Commission's 2005 White Paper contained recommendations organized around three strategies for improving the medical liability system while preventing patient injury. The recommendations that came from the expert panel are characterized as ones that would:

- pursue patient safety initiatives to prevent medical injury
- promote open communication between patients and practitioners, and
- create an injury compensation system that is patient-centered and serves the common good

In this testimony, we would like to mention a few of the specific recommendations in each category that may be of interest to Congress.

I. Pursuing Patient Safety Initiatives to Prevent Medical Injury

Despite the lapse of six years since the IOM's seminal report on medical error, "To Err is Human," medical error remains ubiquitous in health care delivery. Progress has been made, but the health care industry has not been able to emulate the safety successes of other industries, such as aviation and manufacturing, which rely heavily on near-miss and error reporting to "learn from mistakes. A significant problem rests is the failure of many health care organizations and institutions to adopt a culture of safety and commit to systems redesign where necessary. There are substantial costs –both direct and opportunity costs – for health care organizations that make safety a precondition for all other priorities. These costs include performing "failure mode and effects analyses" on all high risk processes of care within the organization; establishing redundant systems to guard against human factors that contribute to errors; conducting organization-wide training and education; and investing in specific information technology to reduce the likelihood of preventable error. Further, leaders of health care organizations need to "buy-into" the benefits that will accrue to them and to patients if they make these investments.

Recently, the Congress, CMS, and other national stakeholders, such as the Joint Commission, have been working on efforts to align payment with improvements in patient safety and health care quality. We believe that these efforts, sometimes called Pay-for-Performance (P4P), have the potential to encourage health care organizations to acculturate patient safety and systems re-engineering with the goal of reducing incidences of medical injuries. The P4P concept essentially envisions rewards for desired behaviors and outcomes. As we move forward with P4P implementation, it will be important to design these value-based purchasing programs in a way that specifically reward those health care organizations that transform themselves into "safe organizations" and that can demonstrate their adherence to safety principles.

Clinical guidelines are increasingly invoked in court to prove or disprove deviations from the standard of care. The pay-for-performance construct can also encourage appropriate adherence to clinical guidelines to improve quality and reduce liability risk. For example, financial incentives for practicing in accordance with guidelines can accelerate their adoption and use by clinicians who may otherwise be unaware of their content. This will lead to better care in general, but perhaps even more directly related to liability reform are studies that show that adherence to clinical guidelines can reduce legal risk. In one study that focused on obstetrical patients, there was a six fold increase in the risk of litigation for cases in which there was a deviation from relevant clinical guidelines.

Further, pay-for-performance programs at the federal level should be designed to encourage team approaches to care because teamwork has been identified by patient safety experts as an essential factor in reducing the risk of medical error. In aviation, predefined roles and responsibilities for varying scenarios are used to guide team development among pilots, flight attendants and other crew. Applying this approach consistently to health care delivery could increase the timeliness and accuracy of communications –breakdowns of which are commonly implicated sources of serious adverse events. Teamwork can also enlist clinicians and support staff in committing to a common goal –safe and effective care—in the often high pressured and chaotic environment of health care delivery. Pay-for-performance programs need to both reward

team performance and guard against any incentive-based program that is divisive to team approaches to care.

Another opportunity for action is to allow patient safety researcher's access to open liability claims to permit early identification of problematic trends in clinical care. One of health care's principal patient safety success stories is anesthesiology. The American Society of Anesthesiologists uses case analysis to identify liability risk areas, monitor trends in patient injury, and design strategies for prevention. In 2005, the ASA Closed Claims Project—created in 1985—contained 6,448 closed insurance claims. Analyses of these claims have revealed patterns in patient injury in the use of regional anesthesia, in the placement of central venous catheters, and in chronic pain management. Results of these analyses are published in the professional literature to aid practitioner learning and promote changes in practices that improve safety and reduce liability exposure.

Closed claims data analysis is the one way in which the current medical liability system helps to inform improvements in care delivery. However, reliance on closed claims for information related to error and injury is cumbersome at best. It may take years for an insurance or medical liability claim to close. These are years in which potentially vital information on substandard practices remains unknown. Providing patient safety researchers with access to open claims, now protected from external examination, could vastly improve efforts aimed at identifying worrisome patterns in care and designing appropriate safety interventions.

II. Pursuing Open Communication Between Patients and Practitioners

Our society has always valued open communication between patients and practitioners as a way to achieve high quality, safe care. But increasingly there is a "code of silence" when an unexpected and serious adverse event has occurred. An unintended consequence of the tort system is that it inspires suppression of the very information necessary to build safer systems of health care delivery. When it comes to acknowledging and reporting error, there is too often silence between practitioners and patients;

practitioners and their peers; practitioners and the organizations in which they practice; and between health care organizations and oversight agencies.

In addition, the wall of silence is amplified by the fears of physicians and health care organizations about the loss of reputation, accreditation or licensure, and income. The wall of silence severely undermines efforts to create a culture of safety within health care organizations and across the health care system. The White Paper identified two areas in which legislation could be helpful. The first is to pursue legislation that protects disclosure and apology from being used as evidence against practitioners in litigation. Lack of disclosure and communication is the most prominent complaint of patients and their families, who together have become victims of medical error or negligence. Years of wounding and expensive litigation often ensue when families are sometimes only seeking answers.

For patients and their family members, the physical and emotional devastation of medical errors cannot be easily overcome. Research shows that what they want most out of their ordeal is honest and open dialogue about what went wrong, and a "legacy" that their experience serves as a lesson to prevent future occurrences of the same event. It has been demonstrated that when it occurs, they are much less likely to litigate a medical error. However, such communication and assurances are seldom forthcoming, although some prominent medical centers have adopted policies urging physicians to disclose their mistakes and apologies. Today, physicians and CEOs of health care organizations are afraid to make these apologies, expressions of sympathy, or commitments to change because they could be used in court as proof of negligence.

Among our report's recommendations for promoting transparency between patients and providers, we recommend that Congress consider ways to support and encourage state legislation that protects disclosure and apology from being used as evidence against providers in litigation. More protections are needed in order for most caregivers and health care organizations to feel comfortable doing this despite the ethical imperative underlying such disclosure.

The second recommendation made in 2005 was for Congress to enact federal patient safety legislation that provides legal protection for information reported to a designated patient safety organization (PSO.) Again, we are very pleased that Congress passed this legislation last summer, and we are anxious for the Department of Health and Human Services to issue guidance for the establishment of PSOs. This legislation has the potential to unlock information we need to move more rapidly toward "systems-based" health care that protects inevitable human error from reaching the patient.

III. Creating an Injury Compensation System that is Patient-Centered and Serves the Common Good

In terms of restructuring the compensation system, there have been numerous proposals suggested over the past few years for making it both efficient and just for all parties by taking a proactive approach in administering the system. These proposals center on three broad approaches: 1) creation of alternative mechanisms for compensating injured patients, such as through early settlement offers often using schedules of compensation for frequent events; 2) resolving disputes through a so-called "no-fault" administrative system or using special health courts; and 3) shifting liability from a focus on individuals to a focus on organizations and systems. Though these approaches are distinct, they are not in conflict and could easily be combined.

Congress could assist in creating a patient-centered compensation system that is predictable and fair by conducting and funding demonstration projects through the Secretary of Health and Human Services of alternatives to the medical liability system that promote patient safety and transparency; that provide swift, equitable compensation to injured patients; and that encourage continued development of mediation and early-offer initiatives.

We need to test the feasibility and effectiveness of alternative injury compensation systems that are patient-centered and focused on safety. Such demonstration projects are needed to begin the process of mitigating the periodic medical liability crises that, aside

from economic factors, result from the delivery of unsafe care, unreliable adjudication of claims, and unfair compensation for injured patients.

There are a large number of innovative suggestions geared to moving away from traditional tort litigation. Inherent to all of these ideas should be highly placed value on immediate acknowledgement of the error or injury; an apology; and assurances that steps will be taken to avoid such an error in the future.

Another potential action would be to redesign or replace the National Practitioner Data Bank (NPDB). Six years ago, the GAO recommended a significant overhaul of DHHS' data bank that collects information on adverse actions against clinicians in order to make it effective. No real change has occurred since that year 2000 report which found that the data were biased in favor of settlements and under-reported other information which was more reflective of practitioners' competence – such as disciplinary and hospital actions. Because of its operational, the NPDB represents a significant threat to physicians and is not useful for those who query in to better understand the competencies of clinicians who they want to hire. It also provides no insight into the actions that are reported, and disciplinary actions are vastly underreported. There is a need for a centralized data base that can capture important performance information about all licensed practitioners, but the NPDB needs significant overhaul to make it useful.

Conclusion

It is our contention that neither patients nor health care providers are well served by the current medical liability system. The central question is how the medical liability system can be restructured to actively encourage physicians and other health care professionals to participate in patient safety improvement activities. It is clearly time to actively explore and test alternatives to the medical liability system that stimulate the creation of "just cultures." This type of health care environments fosters learning—including learning from mistakes—and emphasizes individual accountability for misconduct.

Redesigning the medical liability system will necessarily be a long-term endeavor. This redesign will take a concerted effort by all stakeholders in which the legal and medical systems work together to solve these interrelated systems. Our mutual goal should be to reduce litigation by decreasing patient injury; by encouraging open communication and disclosure among patients and providers, and by assuring prompt, fair compensation when safety systems fail.